Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-014116
STATE FILE NUMBER

FILED APR 24 1959 Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 109

1. PLACE OF DEATH
a. COUNTY: Marion
b. CITY OR TOWN: Hannibal — Inside Limits: Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION: St. Elizabeth Hospital — Length of stay in 1b:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Marion
c. CITY OR TOWN: Hannibal 0644 — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 2703 Hiawatha — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First CLARENCE Middle JAMES Last DODD

4. DATE OF DEATH: Month April Day 11 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: August 5, 1872
9. AGE (In years last birthday): 86 — IF UNDER 1 YEAR: Months 8 Days 6 — IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (City and state or country): Carrolton Missouri
12. CITIZEN OF WHAT COUNTRY?: U S A

13a. FATHER'S NAME: James H. Dodd
13b. MOTHER'S MAIDEN NAME: Jane Martin
14. NAME OF HUSBAND OR WIFE: Lora (Deceased 1933)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No — None
16. SOCIAL SECURITY NO.: 493 28 6208
17. INFORMANT Address: Mrs. A. F. Paynter Hannibal Missouri

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Ruptured ileum — 36 hrs
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Apr 10 -59, to Apr 11-59, and last saw him alive on Apr 11-59
Death occurred at 8:00 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): A. F. Paynter (M.D.)
22b. ADDRESS: Hannibal Mo
22c. DATE SIGNED: 4-14-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 4/14/1959
23c. NAME OF CEMETERY OR CREMATORY: Mount Olivet Cemetery
23d. LOCATION (City, town, or county) (State): Hannibal Missouri

24. FUNERAL DIRECTOR ADDRESS: W. Crawford Smith Hannibal Missouri
25. DATE RECD. BY LOCAL REG.: 4-15-1959
26. REGISTRAR'S SIGNATURE: Dr. E. M. Luckey by K. C. Fisher

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
All diseases in Part I must be causally related.

DATE FILED APR 22 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. ..... working under my personal supervision.

Student ..... Signed W. Crawford Smith

Signature of Student Embalmer

Licensed Embalmer No. 7814

P. O. Address Hannibal, Missouri

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.